



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

LANDMARK EXAMS

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-15-1310-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

December 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim has still been denied in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of \$2,750.00 for this claim and were paid nothing. The explanation given on the correspondence justifying the denial states: W-9 UNNECESSARY TREATMENT WITH PEER REVIEW; however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: \$1,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, the bill was sent for additional review. Payment in the amount of \$1,150.00 will be issued on 1/22/15. Attached is a copy of the EOR and payment screen."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2013	CPT Code 99456-W5-WP, 99456-W6-RE, 99456-MI and 99456-SP	\$1,200.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W9- Unnecessary treatment with peer review
 - 18 – Duplicate claim/service

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The insurance carrier response dated January 20, 2015 states "Upon receipt of the MDR, the bill was sent for additional review. Payment in the amount of \$1,150.00 will be issued on 1/22/15. Attached is a copy of the EOR and payment screen." The requestor in a email states dated March 24, 2015 that payment of \$1,150.00 was received.
2. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is November 12, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 30, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

4/10/15

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.